VIBRANT SOL CHIROPRACTIC KIDS

HEALTH INTAKE FORMS

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date_____

Name_____ **Age** _____ **Birthdate**_____

Home Address_____ **City** _____ **State**_____ **Zip** _____

Parent's Name(s)_____ **E-mail address**_____

Best phone (____) _____

Emergency contact name _____ **Emergency Contact Phone**_____

How did you hear about us? _____

MOTHER'S PREGNANCY AND LABOR

During pregnancy did the mother:

- Take any medication? ☐ No ☐ Yes Explain: _____
- Smoke or Consume alcohol? ☐ No ☐ Yes Explain: _____
- Experience any maternal complications or illness? ☐ No ☐ Yes Explain: _____

_____

Approximately how long did labor last? _____ Was labor assisted? ☐ Yes ☐ No

Was labor chemically induced? ☐ Yes ☐ No

Was labor doctor assisted? ☐ Yes ☐ No

Was a C-Section performed? ☐ Yes ☐ No

Were forceps or vacuum used? ☐ Yes ☐ No

Did the delivery doctor pull or twist the baby during delivery? ☐ No ☐ Yes Explain:_____

_____

Was the delivery premature? If yes, @ _____ weeks and _____ weight

Please check any of the following that your child experienced immediately after birth:

- ☐ Jaundice
- ☐ Respiratory Problems
- ☐ Feeding Difficulty
- ☐ Lip or Tongue Tie
- ☐ Torticollis
- ☐ Displaced or Broken Joints

Other Condition(s) Explain: _____

REASON FOR VISIT

Describe the purpose for you visit_____?

When did this symptom begin? _____

Is this symptom (mark all that apply):

- ☐ Getting Worse
- ☐ Getting Better
- ☐ No Changes
- ☐ Comes and Goes
- ☐ Constant/Frequent
- ☐ Infrequent/ Intensity Varies

Does this symptom interfere with (circle all that apply):

Sleep Daily routine Appetite Digestion Breastfeeding Mood Comfort

Has your child received any previous treatment for this symptom? ☐ Yes ☐ No

Type of treatment: _____

Results: _____

CHILD'S HEALTH HISTORY

Please check each of the conditions that your child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

☐ Vision Problems	☐ Chronic Infection
☐ Difficulty Latching	☐ Ear Problems
☐ Sleeping Disorders	☐ Bed Wetting
☐ Irritability	☐ Attention Problems
☐ Skin Problems	☐ Frequent Colds
☐ Difficult to Soothe	☐ Constipation
☐ Breathing Problems	☐ Digestive Problems
☐ Trouble Falling Asleep	☐ Hard to Stay Asleep
☐ Noisy while sleeping	☐ Straining to Eliminate
☐ Spitting Up	☐ Excessive Drool
☐ Clicking while feeding	☐ Reflux
☐ Colic	☐ Frequent Falls
☐ Food Sensitivity	☐ Failure to Thrive
☐ Sensitive Gag Reflex	☐ Startled Easily
☐ Developmental Delay(s)	☐ Speech Pathology

CHILD'S CURRENT Health STATUS

Has your child:

Been hospitalized ☐ Yes ☐ No

Had a severe fall ☐ Yes ☐ No

Been in a car accident ☐ Yes ☐ No

Has your child ever taken antibiotics? ☐ Yes ☐ No

How many rounds? _____ How often?_____

If your child currently taking any medication please list and explain:_____

_____

CHILD'S CURRENT HEALTH STATUS CONT.

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have your or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? ☐ Yes ☐ No

Has your child been vaccinated? ☐ Yes ☐ No

Which do you follow:

- ☐ Full Schedule
- ☐ Delayed Schedule
- ☐ Modified Doses
- ☐ Other:_____

Has your child experience any vaccine side effects?

☐ Redness	☐ Lethargy	☐ Rash	☐ Fever
☐ Soreness	☐ Diarrhea	☐ Joint Pain	☐ Swelling
☐ Vomiting			

Please list the meals your child most often consumes:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Other _____

GOALS FOR MY CHILD

In your own words, describe the changes that you would like to see in your child:

_____
_____
_____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors at Vibrant Sol Chiropractic and whomever they may designate as their assistants to administer chiropractic care, to work with my child (Child's Name) _____ through the use of adjustments and treatments to the head and spine, as the Doctors deems appropriate.
I have read and understand the Informed Consent document. Please consider my signature as acknowledgment that I have been informed of all risks and contraindications for an adjustment. I understand and agree that only a parent or legal guardian can authorize chiropractic care and must be present for all treatments. Service may be refused if your child is brought to their appointment without a parent or legal guardian. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment at the time of service. I agree that I am responsible for all bills incurred at this office. In the event a 3rd party is involved in the payment for services rendered, I understand that services denied or not paid at the rate anticipated remain my personal responsibility. The Doctors will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

_____	_____	_____
Print Parent/Guardian's Name	Parent/Guardian Signature Authorizing Care	Date

FINANCIAL INFORMATION

Payment in full is expected to be paid at time of service unless other arrangements have been made and agreed upon in writing prior to the service. Due to variations in insurance policy coverage and fee schedule changes, we can provide you with the most accurate quote of coverage over the phone or in person. For information on fees associated with your first visit please contact us at 405.739.0594.

INSURANCE

We will need a copy of your driver's license and insurance card to keep on file.

Name of Insurance Co. _____ Policy # _____

Name of Insured: _____ Insured SS# _____ Insured DOB _____

Are you covered by more than one insurance company? Yes No Name of 2nd _____

If this is an Auto Accident or a Work-Related injury, please provide us with the following information:

Name of Auto Insurance Co: _____

Policy or Claim Number: _____

Have you been treated elsewhere? ☐ Emergency Room ☐ Primary Care Doctor ☐ Other_____

What services were provided? ☐ MRI ☐ X-Rays ☐ Medication ☐ Therapy ☐ Other_____

PLEASE READ AND SIGN BELOW

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give the doctors permission to render care to me. I understand I am responsible for payment at the time of service. I have confirmed my payment election. I am aware this initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.
I attest that all parents and/or legal guardians are in acceptance of chiropractic care and recommended services, written and verbal, comprehensively.

_____	_____	_____
Print Parent/Guardian's Name	Parent/Guardian Signature Authorizing Care	Date

Thank you for choosing Vibrant Sol Chiropractic. We look forward to optimizing your child's quality of life!